

**Montgomery County Department of Transportation**  
**Medical Assistance Transportation Program, Maryland**  
**101 Monroe Street, 5<sup>th</sup> Floor, Rockville, Maryland 20850-2540, PHONE: 240/777-5890, FAX: 240/777-5891**  
**STATEWIDE MEDICAL ASSISTANCE PROVIDER CERTIFICATION TO BE COMPLETED FOR ALL OUT OF AREA TRANSPORTS**

PLEASE PRINT CLEARLY & COMPLETELY – FAILURE TO DO SO WILL RESULT IN DELAYS AS INCOMPLETE AND ILLEGIBLE FORMS MUST BE RETURNED

**SECTION 1 - PATIENT PERSONAL INFORMATION:**

Last Name:		First Name:	
Address:		City/State/Zip:	
Bldg or Facility Name:	Room/Bed #	Patient Contact/Phone:	
DOB:		Social Security Number (Optional):	
Medical Assistance Number:	Medicare Number:	Other Insurance:	

**SECTION 2 – REFERRAL INFORMATION:**

Name of Facility (if applicable):	
Provider Name:	Provider Phone:
Complete Physical Address (including room/suite/bed# if applicable) and zip code:	
Provider Specialty	Date/Time of Appointment:
Primary Diagnosis and Relevant Secondary Diagnosis(es): DO NOT Enter ICD or DSM Codes	List Relevant Associated Symptoms:

**MA Transportation is only required to transport to the CLOSEST appropriate provider and not necessarily to the one that may be preferred**

**Reason patient is being see out-of-area. Please check one!**

- |  |  |
|--|--|
| <input type="checkbox"/> Procedure not available locally   | <input type="checkbox"/> No specialist available locally |
| <input type="checkbox"/> Specialist available locally who participates with Medical Assistance, but does not participate with client's MCO | <input type="checkbox"/> Other (explain) _____           |
| <input type="checkbox"/> Specialist available locally, but does not participate with Medical Assistance/ Health Choice                     | _____  |

**PROVIDER CERTIFICATION: To be completed ONLY by a Physician, Physician Assistant, Certified Nurse Practitioner (CRNP) or Dentist and must include Medical Assistance or NPI Number**

By signing this form, you are certifying:

1. The services described are medically necessary AND
2. You understand that information provided is subject to investigation and verification. Misrepresentation or falsification of essential information which leads to inappropriate payment may lead to sanctions and/or penalties under applicable Federal and/or State law.
3. This form is valid for a period not to exceed one year from the date of signing.

Check Provider Type: <input type="checkbox"/> Physician <input type="checkbox"/> CRNP <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Dentist		
Signature of Provider:	Date Signed:	Provider's Medical Assistance Or NPI Number:
Printed Name of Provider:	Printed <u>Full</u> Address of Provider:	
Provider's Telephone Number:		

## Instructions to Complete the Out of Area Certification Form

### Section 1- Patient Personal Information – may be completed by patient or provider

Patient's Name and Address	Enter the patient's Last Name, First Name. A complete and correctly spelled name is crucial for proper patient identification. Enter the patient's home address. If the patient is a resident of an inpatient facility, enter the name and address of the facility along with room and bed number.
Telephone Number	Enter the contact number for the patient (i.e. home telephone number or cell number). If patient is a resident at an inpatient facility, enter the inpatient facility telephone number.
Date of Birth	Enter the patient's date of birth as mm/dd/yyyy
Patient's Social Security #	The patient's social security number is optional .
Patient's 11-digit MA #	Enter the patient's 11-digit Medical Assistance number. Do not enter the MCO identification Number.
Patient's Medicare #	If applicable, enter the patient's 9-digit Medicare number along with the applicable "letters"
Other Insurance	If applicable, enter other insurance information – ID number and name of other insurance

### Section 2 – Referral Information

Name of Facility (if applicable)	Facility where patient is being referred
Provider Name	Name of provider to whom patient is being referred
Provider Phone	Telephone number of the provider where patient is being referred
Complete Physical Address	Address of provider where patient is being referred. Include room/suite/bed number along With zip code.
Provider Specialty	Medical discipline of the provider where patient is being referred e.g. cardiology, oncology etc.
Date/Time of Appointment	Time and date of appointment of provider where patient's is being referred
Primary Diagnosis and relevant secondary diagnosis(es)	Do not enter ICD or DSM Codes
List Relevant Associated Symptoms	Symptoms resultant from the above listed diagnoses

### **PLEASE CHECK REASON WHY PATIENT IS BEING SEEN OUT-OF-AREA**

Provider Type	Check appropriate box. Only physician, physician assistant, CRNP and dentist are 'Authorized" to certify
Signature of Provider	Signature of provider is mandatory or will be returned which will delay transportation services
Date Signed	Enter date signed
Provider's Medical Assistance or NPI #	Enter referring Provider's Medical Assistance or NPI #. This number is needed to verify provider's participation in the Medical Assistance Program
Provider's Telephone #	Enter referring Provider's telephone number
Provider's Full Address	Enter referring Provider's full address.